

# Docosahexaenoic Acid but Not Eicosapentaenoic Acid Lowers Ambulatory Blood Pressure and Heart Rate in Humans

Trevor A. Mori, Danny Q. Bao, Valerie Burke, Ian B. Puddey, Lawrence J. Beilin

**Abstract**—Animal studies suggest that the 2 major  $\omega$ 3 fatty acids found in fish, eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA), may have differential effects on blood pressure (BP) and heart rate (HR). The aim of this study was to determine whether there were significant differences in the effects of purified EPA or DHA on ambulatory BP and HR in humans. In a double-blind, placebo-controlled trial of parallel design, 59 overweight, mildly hyperlipidemic men were randomized to 4 g/d of purified EPA, DHA, or olive oil (placebo) capsules and continued their usual diets for 6 weeks. Fifty-six subjects completed the study. Only DHA reduced 24-hour and daytime (awake) ambulatory BP ( $P < 0.05$ ). Relative to the placebo group, 24-hour BP fell 5.8/3.3 (systolic/diastolic) mm Hg and daytime BP fell 3.5/2.0 mm Hg with DHA. DHA also significantly reduced 24-hour, daytime, and nighttime (asleep) ambulatory HRs ( $P = 0.001$ ). Relative to the placebo group, DHA reduced 24-hour HR by  $3.5 \pm 0.8$  bpm, daytime HR by  $3.7 \pm 1.2$  bpm, and nighttime HR by  $2.8 \pm 1.2$ . EPA had no significant effect on ambulatory BP or HR. Supplementation with EPA increased plasma phospholipid EPA from  $1.66 \pm 0.07\%$  to  $9.83 \pm 0.06\%$  ( $P < 0.0001$ ) but did not change DHA levels. Purified DHA capsules increased plasma phospholipid DHA levels from  $4.00 \pm 0.27\%$  to  $10.93 \pm 0.62\%$  ( $P < 0.0001$ ) and led to a small, nonsignificant increase in EPA ( $1.52 \pm 0.12\%$  to  $2.26 \pm 0.16\%$ ). Purified DHA but not EPA reduced ambulatory BP and HR in mildly hyperlipidemic men. The results of this study suggest that DHA is the principal  $\omega$ 3 fatty acid in fish and fish oils that is responsible for their BP- and HR-lowering effects in humans. These results have important implications for human nutrition and the food industry. (*Hypertension*. 1999;34:253-260.)

**Key Words:** eicosapentaenoic acid ■ docosahexaenoic acid ■ fatty acids ■ blood pressure ■ heart rate

Current evidence from epidemiological studies, clinical trials, and experimental animal studies suggests that  $\omega$ 3 fatty acids of marine origin may be protective against cardiovascular disease.<sup>1</sup> Most studies that assessed the potential cardiovascular benefits of  $\omega$ 3 fatty acids have focused largely on the importance of eicosapentaenoic acid (EPA), with little attention given to the relative effect of docosahexaenoic acid (DHA). This is probably attributable to the fact that the majority of commercial marine oil preparations as well as most, but not all, fish species contain more EPA than DHA. In addition, EPA, unlike DHA, is a substrate for the cyclooxygenase and lipoxygenase enzymes involved in eicosanoid metabolism.

Fish oil supplementation in humans results in substantial increases in plasma and tissue  $\omega$ 3 fatty acids, particularly EPA and DHA, but with variable incorporation in different phospholipid classes in different tissues. In vitro animal and human studies have shown that EPA and DHA are differentially incorporated into plasma,<sup>2</sup> platelet,<sup>3,4</sup> and tissue lipids.<sup>4</sup> These differences may play an important role in the utilization and metabolism of the 2 fatty acids. For example, EPA

and DHA differ in their effects on membrane fluidity and the activities of membrane-bound enzymes<sup>5</sup> and on neutrophil-mediated endothelial detachment.<sup>6</sup> Compelling evidence shows that in vitro DHA but not EPA decreased cytokine-induced expression of endothelial leukocyte adhesion molecules.<sup>7</sup> Recent reports have described differences in lipid metabolism<sup>8,9</sup> and platelet aggregation.<sup>10</sup>

An antihypertensive effect of fish oils has been demonstrated in hypertensive patients,<sup>11-14</sup> although generally only when relatively large doses of fish oils have been used. We recently reported that daily fish meals that provide 3.65 g/d of  $\omega$ 3 fatty acids significantly reduced blood pressure (BP) in overweight, treated hypertensives.<sup>15</sup> This study addresses the question of whether EPA and DHA have differential effects on BP and heart rate (HR) in humans. In support of a differential effect of EPA and DHA on BP control, McLennan et al<sup>16</sup> recently reported that DHA was more effective than EPA at retarding the development of hypertension in spontaneously hypertensive rats (SHR) but not in adult SHR with already established hypertension. In addition, DHA but not EPA inhibited ischemia-induced cardiac arrhythmias at low dietary intakes in Hooded Wistar rats.<sup>16</sup> At

Received February 22, 1999; first decision March 10, 1999; revision accepted April 6, 1999.

From the Department of Medicine, University of Western Australia, and the West Australian Heart Research Institute, Perth, Australia.

Reprint requests to Dr Trevor A. Mori, University Department of Medicine, Medical Research Foundation Building, Box X 2213 GPO, Perth, Western Australia 6847. E-mail tmori@cyllene.uwa.edu.au.

© 1999 American Heart Association, Inc.

*Hypertension* is available at <http://www.hypertensionaha.org>

moderate to high dietary intakes, DHA was also more effective than EPA at inhibiting thromboxane-like vasoconstrictor responses in the aortas from SHR.<sup>16</sup> Other studies have shown that dietary DHA prevented the development of hypertension in the stroke-prone SHR<sup>17</sup> and that EPA, compared with  $\gamma$ -linoleic acid, reduced the elevation of BP in the SHR without affecting HR.<sup>18</sup> In contrast, in the only human study to date, EPA and DHA supplementation in healthy, nonsmoking men failed to show any difference between the 2 fatty acids or any change in BP.<sup>19</sup>

Given the in vitro and in vivo data from animal studies that suggest that EPA and DHA may differ in their effects on BP and HR, we conducted a double-blind, randomized, placebo-controlled study to examine these possible differences in mildly hyperlipidemic men who are at increased risk of cardiovascular disease.

## Methods

### Study Population

Mildly hyperlipidemic (cholesterol  $\geq 6$  mmol/L and/or triglyceride  $\geq 1.8$  mmol/L) but otherwise healthy, nonsmoking men between the ages of 20 to 65 years were recruited from the general community by media advertising. Entry criteria included a body mass index between 25 and 30 kg/m<sup>2</sup>, with no recent (previous 3 months) symptomatic heart disease, diabetes, or liver or renal disease (plasma creatinine  $>130$   $\mu$ mol/L); and not on regular nonsteroidal anti-inflammatory drug therapy, antihypertensive drugs, or lipid-lowering or other drugs that affect lipid metabolism. All subjects usually ate not  $>1$  fish meal per week and drank  $<210$  mL of ethanol per week. Fifty-nine of 136 subjects screened satisfied the entry criteria. The study was approved by the ethics committee of the Royal Perth Hospital, and all subjects gave written consent. All procedures performed were in accordance with institutional guidelines.

### Dietary Education and Intervention

During a 3-week baseline period, subjects continued their usual diet and alcohol intake and, after collection of baseline measurements, were randomly assigned to 1 of 3 groups and matched for age and body mass index. Treatment groups were allocated to 4 g/d of EPA, DHA, or olive oil placebo capsules. Capsules that contained purified preparations of EPA ethyl ester ( $\approx 96\%$ ), DHA ethyl ester ( $\approx 92\%$ ), or olive oil ( $\approx 75\%$  oleic acid ethyl ester) were provided by the Fish Oil Test Materials Program and the US National Institutes of Health and Department of Commerce. During the 6 weeks of intervention, all volunteers were asked to maintain their usual diets, alcohol intake, and physical activity and not to alter their lifestyle.

At an initial interview with a dietitian, subjects were given written and oral instructions on how to keep diet records, with food weighed or measured. Dietary intake was monitored by the same dietitian throughout the study, with completion of a 3-day diet record (2 weekdays and one weekend day) at baseline and repeated at the end of the 6-week intervention. Volunteers were also seen at 2-week intervals by the dietitian, who determined whether their usual eating habits were maintained and reminded them to make no changes.

### Urinary Analytes, Lifestyle Assessment, and Anthropometry

Twenty-four-hour urinary sodium, potassium, calcium, and creatinine were measured at baseline and at the end of the intervention. Alcohol intake, physical activity, and use of medications were monitored every second week during the intervention with 7-day retrospective diaries. Weight was measured on an electronic scale; subjects wore light clothing and did not wear shoes. Height was measured with a stadiometer.

TABLE 1. Baseline Characteristics of Participants

	Olive Oil (n=20)	EPA (n=19)	DHA (n=17)
Age, y	48.4 $\pm$ 2.0	48.9 $\pm$ 1.7	49.1 $\pm$ 2.2
BMI, kg/m <sup>2</sup>	28.4 $\pm$ 0.5	29.0 $\pm$ 0.7	28.9 $\pm$ 0.7
Waist-to-hip ratio	0.94 $\pm$ 0.01	0.93 $\pm$ 0.01	0.94 $\pm$ 0.01
Serum cholesterol, mmol/L	6.47 $\pm$ 0.21	6.20 $\pm$ 0.20	6.18 $\pm$ 0.18
Serum triglycerides, mmol/L	2.04 $\pm$ 0.19	2.01 $\pm$ 0.19	2.25 $\pm$ 0.40
Supine systolic BP, mm Hg*	119.1 $\pm$ 2.3	120.6 $\pm$ 2.6	124.2 $\pm$ 3.1
Supine diastolic BP, mm Hg*	71.4 $\pm$ 1.4	73.6 $\pm$ 1.8	75.2 $\pm$ 1.6
Supine heart rate, bpm*	64.1 $\pm$ 1.9	66.1 $\pm$ 1.7	65.5 $\pm$ 2.1

Values are expressed as mean $\pm$ SEM.

\*Average from 20 readings on 2 separate days in the clinic with a Dinamap 1846 SX/P monitor. Baseline measures were compared by 1-way ANOVA and were not significantly different.

### Ambulatory BP Monitoring

Ambulatory BP (ABP) was monitored over 24 hours at baseline and at the end of intervention with an ambulatory blood pressure monitoring system (Accutacker II, Suntech Model 104) fitted by a trained nurse who instructed the subject on its use. The recorder was preset to record BP and HR every 30 minutes during waking hours (daytime) and hourly during sleep (nighttime). BP records were not visible to the subjects. Volunteers completed a diary that indicated their activity at the time of the ABP reading. When the monitoring system detected an error in BP measurement, subjects were instructed to rectify the error or return to the department to have the recorder corrected. After readjustment of the recorder, a BP reading was initiated to check correct functioning. Readings associated with a test code and those with a difference of  $<20$  mm Hg between systolic blood pressure (SBP) and diastolic blood pressure (DBP) were excluded from analysis.

### Plasma Phospholipid Fatty Acids

Total  $\omega 3$  fatty acids measured in plasma phospholipids included 20:5, 22:5, and 22:6, and  $\omega 6$  fatty acids included 20:3, 20:4, and 22:4. Fatty acid analysis of plasma phospholipids was determined according to previously described procedures.<sup>20</sup>

### Statistical Analysis

Diet records were analyzed with the use of a nutrition analysis software package (Diet 1 version 4, Xyris software) based on the NUTTAB database of Australian foods (1995A).<sup>21</sup> Data were analyzed by SPSS (SPSS Inc) with general linear model analysis to assess the effects of EPA and DHA. Significance levels were adjusted for multiple comparisons by the Bonferroni method. Values are mean $\pm$ SEM.

## Results

### Study Population

Fifty-six of 59 subjects randomized completed the study. Those who withdrew were either unable to maintain the schedule of laboratory visits or comply with the capsules; 1 subject withdrew because of gastrointestinal symptoms. Baseline characteristics of the 3 groups are shown in Table 1 and confirmed that they were well matched for the entry criteria. Clinic SBP and DBP were higher in the DHA group but not significantly different from the control and EPA groups (supine SBP,  $P=0.324$ ; supine DBP,  $P=0.251$ ). No significant differences existed between the groups for any of the other variables at baseline.

**TABLE 2. Body Weight, 24-h Urinary Sodium, Potassium, and Creatinine Excretion at Baseline and Postintervention**

	Olive Oil (n=20)	EPA (n=19)	DHA (n=17)
Body weight, kg*			
Baseline	88.7±2.0	89.1±2.3	90.8±2.8
Postintervention	88.9±2.1	89.3±2.3	91.1±2.9
Urinary Na <sup>+</sup> , mmol/24 h			
Baseline	151.3±10.6	187.3±18.6	189.5±19.9
Postintervention	209.2±16.2	209.8±15.9	182.5±14.9
Urinary K <sup>+</sup> , mmol/24 h			
Baseline	78.5±4.0	83.2±4.9	84.1±5.3
Postintervention	84.1±4.3	89.0±6.1	80.1±5.2
Urinary creatinine, mmol/24 h			
Baseline	14.3±0.6	14.8±0.5	15.5±0.7
Postintervention	14.2±0.6	15.8±0.9	14.5±0.6
Urinary Na <sup>+</sup> /K <sup>+</sup>			
Baseline	2.0±0.1	2.3±0.3	2.3±0.2
Postintervention	2.7±0.2	2.3±0.2	2.4±0.3
Urinary Na <sup>+</sup> /Creatinine			
Baseline	10.8±0.8	12.7±1.1	12.2±1.2
Postintervention	15.2±1.2	13.4±0.9	12.1±1.3

Values are expressed as mean±SEM. Baseline measures were compared by 1-way ANOVA and were not significantly different between groups. With general linear model analysis, there were no significant treatment effects for postintervention urinary sodium, potassium, creatinine, Na<sup>+</sup>/K<sup>+</sup> ratio, and Na<sup>+</sup>/creatinine ratio after adjustment for age, baseline weight, and baseline value.

\*Postintervention body weight was analyzed after adjustment for age and baseline value.

### Energy and Macronutrient Intake

No significant difference in body weight existed between the groups at baseline, and there was no significant change in weight during intervention in the 3 groups (Table 2). Analysis of diet records confirmed that total energy intake was not different at baseline between groups and remained unchanged during the 6 weeks of the intervention (Table 3). Similarly, there were no significant differences between the groups in any of the dietary nutrients at baseline, nor were there any significant changes during the intervention (Table 3). Alcohol consumption and physical activity remained unchanged during the intervention in all groups.

### Plasma Phospholipid Fatty Acids

At baseline, there were no significant differences between groups in plasma phospholipid fatty acids, including EPA and DHA content. The changes in EPA and DHA from baseline to the end of intervention indicated compliance with capsule intake. After supplementation with purified EPA, plasma phospholipid 18:2 $\omega$ 6 decreased (20.92±0.47% to 16.00±0.52%,  $P<0.0001$ ), 20:4 $\omega$ 6 decreased (12.18±0.43% to 9.34±0.32%,  $P<0.0001$ ), and EPA increased from 1.66±0.07% to 9.83±0.06% ( $P<0.0001$ ). At the same time, DHA composition remained relatively unchanged (4.11±0.24% to 4.02±0.13%,  $P>0.05$ ). Supplementation with purified DHA increased the phospholipid composition

of DHA from 4.00±0.27% to 10.93±0.62% ( $P<0.0001$ ) and also led to a small, nonsignificant ( $P=0.383$ ) increase in the EPA content (1.52±0.12% to 2.26±0.16%). Both 18:2 $\omega$ 6 (21.04±0.49% to 18.22±0.62%,  $P<0.0001$ ) and 20:4 $\omega$ 6 (11.25±0.42% to 8.82±0.32%,  $P<0.0001$ ) were reduced. Olive oil supplementation did not alter 18:2 $\omega$ 6, 20:4 $\omega$ 6, EPA, or DHA composition of plasma phospholipids.

### Urinary Electrolytes

For all subjects combined, the mean 24-hour urinary sodium and potassium excretion values at baseline were 175.1±9.6 and 81.8±2.7 mmol/24 hours, respectively (Table 2). This was not significantly different between groups. With general linear model analysis, no significant treatment effects existed for postintervention urinary sodium after adjustment for age, baseline weight, and baseline value. Urinary potassium and creatinine excretion and the sodium/potassium and sodium/creatinine ratios were not significantly different between groups at baseline and at completion of the study (Table 2).

### Ambulatory Blood Pressure

The mean values for SBP and DBP at baseline and postintervention during the 24 hours of ABP monitoring for each group are shown in Figure 1. Mean 24-hour, daytime, and nighttime ABP by group are shown in Table 4. Although baseline mean 24-hour BP was higher in the DHA group by  $\approx 5/3$  mm Hg (SBP/DBP), this was not significantly different from the control and EPA groups (SBP,  $P=0.257$ ; DBP,  $P=0.189$ ). Supplementation with DHA significantly reduced blood pressure. In general linear model analysis, with mean 24-hour BP as the dependent variable, DHA significantly effected the reduction of the SBP ( $-5.8\pm 2.1$  mm Hg,  $P=0.022$ ) and DBP ( $-3.3\pm 1.3$  mm Hg,  $P=0.029$ ) compared with the olive oil placebo after adjustment for age, baseline weight, and baseline BP. There was also a significant effect of DHA on mean daytime SBP ( $-3.5\pm 2.9$  mm Hg,  $P=0.041$ ) and DBP ( $-2.0\pm 1.1$  mm Hg,  $P=0.046$ ) compared with the placebo group after adjustment for age, baseline weight, and baseline value. There was no significant effect of DHA on mean nighttime SBP and DBP. The results remained significant in models that adjusted for changes in urinary sodium, potassium, or creatinine or the sodium/potassium ratio. There was no significant effect of EPA on 24-hour, daytime, or nighttime BP.

### Heart Rate

Hourly mean values for HR at baseline and postintervention during the 24 hours of ABP monitoring for each group are shown in Figure 1. Mean 24-hour, daytime, and nighttime HRs by treatment group are shown in Table 4. Relative to controls, there was a significant effect of DHA on 24-hour ( $-3.5\pm 0.8$  bpm,  $P=0.001$ ), daytime ( $-3.7\pm 1.2$  bpm,  $P=0.001$ ), and nighttime ( $-2.8\pm 1.2$  bpm,  $P=0.025$ ) ambulatory HRs after adjustment for age, baseline weight, and baseline value. EPA had no significant effect on 24-hour ambulatory HR.

### Discussion

This study addressed the question as to whether highly purified EPA or DHA administered in the diet differ from one

**TABLE 3. Total Energy Intake and Macronutrients at Baseline and Postintervention**

	Olive Oil (n=20)	EPA (n=19)	DHA (n=17)	ANOVA at Baseline (P) Treatment Effects (P)
Total energy intake, kJ/d				
Baseline	10 441±588	9516±677	10 550±588	NS
Postintervention	9970±704	9652±844	9917±613	NS
Total fat, % of energy				
Baseline	34.2±1.2	30.9±1.6	32.6±1.6	NS
Postintervention	33.7±1.1	33.5±1.7	35.2±1.6	NS
Saturated fat, % of energy				
Baseline	13.6±0.8	12.1±0.9	13.6±0.9	NS
Postintervention	13.6±0.9	13.3±1.0	14.4±1.1	NS
Monounsaturated fat, % of energy				
Baseline	12.2±0.6	11.1±0.8	11.5±0.7	NS
Postintervention	12.0±0.4	12.3±0.8	12.1±0.6	NS
Polyunsaturated fat, % of energy				
Baseline	5.0±0.3	4.2±0.3	4.6±0.2	NS
Postintervention	4.9±0.4	4.6±0.4	5.5±0.5	NS
Protein, % of energy				
Baseline	18.0±0.5	19.8±0.9	18.1±0.6	NS
Postintervention	17.4±0.6	19.0±0.9	18.0±0.7	NS
Carbohydrate, % of energy				
Baseline	42.1±1.7	44.6±1.7	41.8±1.8	NS
Postintervention	44.0±1.2	43.7±1.9	40.5±1.7	NS
Fiber, g/d				
Baseline	30.8±2.9	27.4±1.8	26.1±1.1	NS
Postintervention	27.5±3.1	24.9±2.2	25.4±1.4	NS
Sodium, g/d				
Baseline	3.5±0.2	3.2±0.3	3.4±0.2	NS
Postintervention	3.1±0.3	3.5±0.3	3.4±0.3	NS
Potassium, g/d				
Baseline	3.7±0.2	3.5±0.2	3.6±0.3	NS
Postintervention	3.5±0.2	3.2±0.3	3.4±0.2	NS
Alcohol intake, g/wk				
Baseline	107.4±20.3	98.8±11.4	99.6±14.0	NS
Postintervention	100.3±11.8	86.7±6.2	93.9±11.5	NS

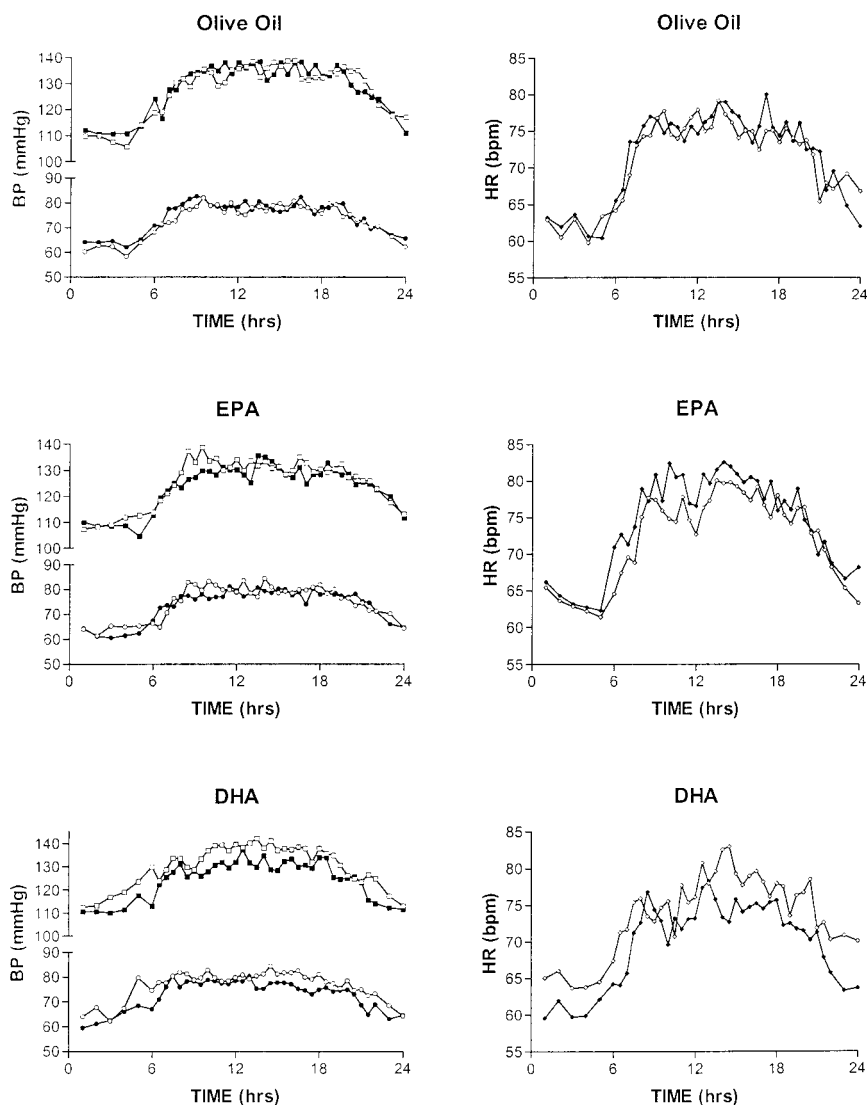
Values are expressed as mean±SEM. Baseline measures were compared by 1-way ANOVA. General linear model analysis was used to test for treatment effects on postintervention values adjusted for baseline value.

another with respect to effects on ABP and HR in humans. The study was performed against a background diet that was carefully standardized for the amount and type of dietary fats in overweight, mildly hyperlipidemic but otherwise healthy men. We found that purified DHA, but not EPA, resulted in a significant reduction in ABP and HR compared with placebo.

Interestingly, the BP-lowering effects of DHA were observed in men with otherwise normal BP. Their mean clinic BP at baseline was 121.2±1.5 mm Hg systolic and 73.3±0.9 mm Hg diastolic. To date, the most impressive results with respect to  $\omega$ 3 fatty acid effects on BP control have been observed in hypertensive patients.<sup>11-14</sup> Moreover, the antihypertensive effect in the present study was seen with 4 g/d of DHA, which is at the low end of the range of  $\omega$ 3 fatty

acid intake. Previous trials have suggested that beneficial effects on BP were attainable only with relatively large doses of  $\omega$ 3 fatty acids.<sup>22,23</sup> We recently reported a significant reduction in ABP, particularly in daytime pressures and in overweight, treated hypertensive patients.<sup>15</sup> Patients who ate a daily fish meal that provided 3.65 g of  $\omega$ 3 fatty acids showed a BP fall of 6.8±2.6/5.1±1.7 mm Hg (systolic/diastolic). This finding differs from that reported by Grimsgaard et al,<sup>19</sup> in which neither 4 g/d of EPA nor DHA altered clinical BP in healthy, nonsmoking men. The mean clinical BP at baseline in the study by Grimsgaard et al (122/77 mm Hg) was similar to that of the subjects used in our study. Reasons for the discrepancy between the studies may relate to differences in the background diets or to the improved statistical power in showing a reduction in BP





Twenty-four-hour ambulatory mean SBP, DBP, and HR at baseline and postintervention in the 3 groups: □ indicates baseline SBP; ■, postintervention SBP; ○, baseline DBP; ●, postintervention DBP; ◇, baseline HR; and ◆, postintervention HR.

through the use of ABP monitoring. The technique enables continuous recording of BP every 30 minutes during awake periods and hourly when subjects are asleep. Our subjects were older ( $\approx 5$  years), although it is unlikely that this would have affected the outcome.

There is support in the literature for DHA being the principal active  $\omega 3$  fatty acid of fish and fish oils involved in lowering BP, but to date this has been demonstrated in animals only.<sup>16,17</sup> Kimura et al<sup>17</sup> showed that DHA, compared with a diet free of DHA, prevented the development of hypertension in stroke-prone SHR by inhibiting the increase in SBP in a dose-dependent manner. McLennan et al<sup>16</sup> compared EPA with DHA in rats and related the changes to olive oil. DHA retarded the development of high BP when fed to young prehypertensive SHR. EPA also retarded the development of hypertension, but less so than DHA. Interestingly, neither DHA nor EPA modified BP in the adult SHR with established hypertension. It was found that in the adult SHR, DHA but not EPA reduced the vascular thromboxane-like vasoconstrictor responses in aortas after inhibition of nitric oxide with *N*<sup>ω</sup>-nitro-L-arginine. In contrast,

Sasaki et al<sup>18</sup> showed that EPA, compared with  $\gamma$ -linoleic acid, significantly reduced the rise in BP in 11-week-old SHR.

With animal models, we and others have shown that the antihypertensive effect of  $\omega 3$  fatty acids may be related to improved endothelial vasodilator function,<sup>24,25</sup> reduced pressor reactivity of resistance vessels,<sup>25,26</sup> and increased vascular compliance.<sup>27</sup> We also produced evidence that the increased endothelial relaxant effects were in part due to suppression of thromboxane A<sub>2</sub> or cyclic endoperoxides, with the possible additional effect of enhanced endothelial nitric oxide synthesis.<sup>25</sup> Other investigators<sup>28–30</sup> have shown that the consumption of fish oil in humans leads to reduced forearm vascular reactivity to angiotensin II and norepinephrine. In addition, it was possible to antagonize the blunting effect of fish oils in response to both norepinephrine and angiotensin II in human forearm resistance arteries by oral administration of indomethacin, which suggests that  $\omega 3$  fatty acids exert their suppressive effects partially by modification of the prostanoid products derived from the cyclooxygenase pathway.<sup>31</sup> The mechanisms by which BP is reduced to a greater extent by

**TABLE 4. Mean 24-h, Daytime, and Nighttime BP and HR at Baseline and Postintervention**

	Olive Oil (n=20)	EPA (n=19)	DHA (n=17)	ANOVA at Baseline ( <i>P</i> ) Treatment Effect ( <i>P</i> )	
				EPA	DHA
<b>Mean 24-h SBP, mm Hg</b>					
Baseline	123.0±3.4	122.1±2.2	127.8±3.7		NS
Postintervention	124.0±3.0	119.6±2.3	122.0±3.4	-2.5±1.6 NS	-5.8±2.1 (0.022)
<b>Mean 24-h DBP, mm Hg</b>					
Baseline	70.0±1.2	71.9±1.6	73.6±2.0		NS
Postintervention	71.4±1.1	70.6±1.3	70.3±1.6	-1.3±1.1 NS	-3.3±1.3 (0.029)
<b>Mean 24-h HR, bpm</b>					
Baseline	69.0±2.0	69.6±1.4	71.5±1.7		NS
Postintervention	69.8±1.8	71.6±1.3	68.0±1.5	2.0±1.4 NS	-3.5±0.8 (0.001)
<b>Daytime SBP, mm Hg</b>					
Baseline	133.1±3.6	131.4±2.6	137.7±4.2		NS
Postintervention	133.5±2.8	130.8±2.2	134.2±3.5	-0.6±2.0 NS	-3.5±2.9 (0.041)
<b>Daytime DBP, mm Hg</b>					
Baseline	76.6±1.2	78.0±1.6	79.5±2.0		NS
Postintervention	78.0±1.3	77.9±1.5	76.6±1.8	-0.1±0.7 NS	-2.0±1.1 (0.046)
<b>Daytime HR, bpm</b>					
Baseline	73.8±2.0	75.2±1.5	76.3±1.9		NS
Postintervention	75.5±1.5	77.5±1.6	72.6±1.7	2.7±1.7 NS	-3.7±1.2 (0.001)
<b>Nighttime SBP, mm Hg</b>					
Baseline	112.9±3.5	112.8±2.6	117.9±3.8		NS
Postintervention	114.5±3.0	112.9±2.2	115.7±2.8	0.2±2.2 NS	-2.2±2.1 NS
<b>Nighttime DBP, mm Hg</b>					
Baseline	63.4±1.6	65.8±1.8	67.7±2.1		NS
Postintervention	64.3±1.4	65.5±2.0	66.1±2.0	-0.3±1.5 NS	-1.6±1.6 NS
<b>Nighttime HR, bpm</b>					
Baseline	64.1±2.1	64.0±1.4	66.8±2.1		NS
Postintervention	63.7±1.5	66.3±1.4	64.0±1.9	2.3±1.5 NS	-2.8±1.2 (0.025)

Values are expressed as mean±SEM. Baseline measures were compared by 1-way ANOVA. General linear model analysis was used to test for treatment effects on postintervention values adjusted for age, baseline weight, and baseline value. BP and HR were recorded every 30 minutes during waking hours (daytime) and hourly during sleep (nighttime).

DHA than EPA are not established. McLennan et al<sup>16</sup> postulated that DHA may serve as a regulating lipid to prevent thromboxane-induced contraction and perhaps restore the vasoconstrictor/vasodilator balance after impairment of the nitric oxide-related processes that normally function. It has not yet been established whether DHA inhibits thromboxane synthetase or thromboxane A<sub>2</sub>/prostaglandin H<sub>2</sub>

receptor function.<sup>32</sup> In addition, Hashimoto et al<sup>33</sup> recently showed that rats fed DHA intragastrically had reduced plasma norepinephrine levels. Increased adenylyl purines such as ATP, which is released spontaneously and in response to norepinephrine from segments of caudal artery, were significantly inversely associated with BP. It was speculated that DHA alters membrane fatty acid composition and may

accelerate ATP release from vascular endothelial cells, which, in conjunction with reduced plasma norepinephrine, may be responsible for a reduction in BP.<sup>33</sup>

Reductions in HR similar to those seen in the present study have been reported after the consumption of fish or fish oil supplements.<sup>12,34</sup> We have shown a decrease of  $3.1 \pm 1.4$  bpm ( $P=0.036$ ) in 24-hour and  $4.2 \pm 1.6$  bpm ( $P=0.013$ ) in daytime HR after daily consumption of fish for 16 weeks in overweight, treated hypertensives.<sup>15</sup> The reductions in mean 24-hour, daytime, and nighttime HR with DHA in the present study were significant and comparable to those reported previously.<sup>15</sup> Interestingly, EPA resulted in a small, nonsignificant, rise in HR. Therefore, our results on HR changes are in accordance with those of Grimsgaard et al,<sup>19</sup> in which HR was decreased by 2.2 bpm ( $P=0.006$ ) with DHA and increased by 1.9 bpm ( $P=0.04$ ) with EPA.

The reduction in HR by DHA suggests that there may be a significant cardiac component to the antihypertensive effect of DHA, which is possibly mediated by effects on autonomic nerve function or  $\beta$ -adrenoreceptor activity. Animal studies have demonstrated that  $\omega$ 3 fatty acids are incorporated into myocardial cells and have potent antiarrhythmic effects.<sup>35</sup> It has also been shown that DHA is the major  $\omega$ 3 fatty acid incorporated into myocardial membranes, even when animals have been fed fish oils in which EPA has predominated.<sup>36</sup> These findings suggest an important role for DHA in cardiac function. The antiarrhythmic effects of  $\omega$ 3 fatty acids are thought to be related to their ability to inhibit myocardial  $\text{Ca}^{2+}$  overload,<sup>37</sup> thromboxane production,<sup>38</sup> ischemic acidosis, and ischemic  $\text{K}^+$  loss.<sup>39</sup> In addition, Kang et al<sup>40</sup> and Weylandt et al<sup>41</sup> suggested that free polyunsaturated fatty acids and not polyunsaturated fatty acids in phospholipids had an inhibitory effect on the electrical automaticity and excitability of the cardiac myocyte rather than reduction in cytosolic  $\text{Ca}^{2+}$ . McLennan et al<sup>16</sup> showed that DHA but not EPA prevented ischemia-induced cardiac arrhythmias in Hooded Wistar rats that were fed purified oils for 5 weeks. The authors noted that although both EPA and DHA were antiarrhythmic in isolated neonatal myocytes,<sup>37</sup> the failure of EPA to exhibit antiarrhythmic effects in their study may reflect a threshold dose effect. However, the precise cellular mechanism for a differential effect of DHA and EPA remains unclear.

The results of this study may help clarify the potentially protective mechanisms of dietary  $\omega$ 3 fatty acids against cardiovascular disease and, in particular, demonstrate differential effects of EPA and DHA on BP regulation and HR in humans. The findings may have an important effect on the choice of  $\omega$ 3 fatty acid supplements and on the relative use of EPA and DHA in food nutrition in the form of incorporation into animal feeds or foodstuffs. As increasingly concentrated forms of fish oils are becoming available, their use as "over-the-counter" dietary supplements has increased, and fish oil concentrates are authorized by drug authorities for treatment of patients with certain types of hypertriglyceridemia. Therefore, it is of both theoretical interest and practical importance to understand the relative cardiovascular effects of EPA and DHA and whether the more highly purified compounds have differential effects from the combinations

found in many fish oil extracts and, more importantly, in dietary fish.

In conclusion, this study in mildly hyperlipidemic but otherwise healthy men has shown that DHA may be the principal  $\omega$ 3 fatty acid in fish and fish oils that lowers BP and HR in humans. This observation has important implications for human nutrition and the food industry for incorporation of  $\omega$ 3 fatty acids into the human food chain.

## Acknowledgments

This study was supported by a program grant entitled "Studies in Hypertension and Cardiovascular Disease" from the National Health and Medical Research Council of Australia (L.J.B. and I.B.P.). We acknowledge the technical assistance of Lynette McCahon and Ken Robertson, the diet counseling of Esther Balde and Nardia Ward, and the nursing assistance of Jessie Prestage, Anne-Marie Wlazlowski, and Liz Mortley. Purified EPA, DHA, and olive oil capsules were kindly provided by the Fish Oil Test Materials Program and the US National Institutes of Health and Department of Commerce.

## References

1. Simopoulos AP, Kifer RR, Martin RE, Barlow SM, eds. *Health Effects of  $\omega$  3 Polyunsaturated Fatty Acids in Seafoods*. Basel, Switzerland: S. Karger Publishing; 1991: World Review of Nutrition and Dietetics, Vol 66.
2. Hodge J, Sanders K, Sinclair AJ. Differential utilization of eicosapentaenoic acid and docosahexaenoic acid in human plasma. *Lipids*. 1993;28:525–531.
3. Mori TA, Codde JP, Vandongen R, Beilin LJ. New findings in the fatty acid composition of individual platelet phospholipids in man after dietary fish oil supplementation. *Lipids*. 1987;22:744–750.
4. Froyland L, Vaagenes H, Asiedu DK, Garras A, Lie O, Berge RK. Chronic administration of eicosapentaenoic and docosahexaenoic acid as ethyl esters reduced plasma cholesterol and changed the fatty acid composition in rat blood and organs. *Lipids*. 1996;31:169–178.
5. Brown ER, Subbiah PV. Differential effects of eicosapentaenoic acid and docosahexaenoic acid on human skin fibroblasts. *Lipids*. 1994;29:825–829.
6. Bates EJ, Ferrante A, Harvey DP, Nandoskar M, Poulos A. Docosahexaenoic acid (22:6, n-3) but not eicosapentaenoic acid (20:5, n-3) can induce neutrophil-mediated injury of cultured endothelial cells: involvement of neutrophil elastase. *J Leukoc Biol*. 1993;54:590–598.
7. De Caterina R, Cybulsky MI, Clinton SK, Gimbrone MA Jr, Libby P. The  $\omega$ -3 fatty acid docosahexaenoate reduces cytokine-induced expression of proatherogenic and proinflammatory proteins in human endothelial cells. *Arterioscler Thromb*. 1994;14:1829–1836.
8. Grimsgaard S, Bonna KH, Hansen JB, Nordoy A. Highly purified eicosapentaenoic acid and docosahexaenoic acid in humans have similar triacylglycerol-lowering effects but divergent effects on serum fatty acids. *Am J Clin Nutr*. 1997;66:649–659.
9. Rambjor GS, Walen AI, Windsor SL, Harris WS. Eicosapentaenoic acid is primarily responsible for hypotriglyceridemic effect of fish oil in humans. *Lipids*. 1996;31:S45–S49.
10. Nelson GJ, Schmidt PS, Bartolini GL, Kelley DS, Kyle D. The effect of dietary docosahexaenoic acid on platelet function, platelet fatty acid composition, and blood coagulation in humans. *Lipids*. 1997;32:1129–1136.
11. Knapp HR, FitzGerald GA. The antihypertensive effects of fish oil: a controlled study of polyunsaturated fatty acid supplements in essential hypertension. *N Engl J Med*. 1989;320:1037–1043.
12. Bonna KH, Bjerve KS, Straume B, Gram IT, Thelle D. Effect of eicosapentaenoic acid and docosahexaenoic acid on blood pressure in hypertension. *N Engl J Med*. 1990;322:795–801.
13. Lungershausen YK, Abbey M, Nestel PJ, Howe PRC. Reduction of blood pressure and plasma triglycerides by  $\omega$ -3 fatty acids in treated hypertensives. *J Hypertens*. 1994;12:1041–1045.
14. Toft I, Bonna KH, Ingebretsen OC, Nordoy A, Jenssen T. Effects of n-3 polyunsaturated fatty acids on glucose homeostasis and blood pressure in essential hypertension: a randomized, controlled trial. *Ann Intern Med*. 1995;123:911–918.

15. Bao DQ, Mori TA, Burke V, Puddey IB, Beilin LJ. Effects of dietary fish and weight reduction on ambulatory blood pressure in overweight hypertensives. *Hypertension*. 1998;32:710–717.
16. McLennan P, Howe P, Abeywardena M, Muggli R, Raederstorff D, Mano M, Rayner T, Head R. The cardiovascular protective role of docosahexaenoic acid. *Eur J Pharmacol*. 1996;300:83–89.
17. Kimura S, Minami M, Saito H, Kobayashi T, Okuyama H. Dietary docosahexaenoic acid (22:6n-3) prevents the development of hypertension in SHRSP. *Clin Exp Pharmacol Physiol*. 1995;22(suppl 1):S308–S309.
18. Sasaki S, Nakamura K, Uchida A, Fujita H, Itoh H, Nakata T, Takeda K, Nakagawa M. Effects of  $\gamma$ -linolenic and eicosapentaenoic acids on blood pressure in SHR. *Clin Exp Pharmacol Physiol*. 1995;22(suppl 1):S306–S307.
19. Grimsgaard S, Bonna KH, Hansen JB, Myhre ESP. Effects of highly purified eicosapentaenoic acid and docosahexaenoic acid on hemodynamics in humans. *Am J Clin Nutr*. 1998;68:52–59.
20. Mori TA, Vandongen R, Beilin LJ, Burke V, Morris J, Ritchie J. Effects of varying fat, fish, and fish oils on blood lipids in a randomized controlled trial in men at risk of heart disease. *Am J Clin Nutr*. 1994;59:1060–1068.
21. Lewis J, Holt R. *NUTTAB 91–92: Nutrient Tables for Use in Australia*. Canberra, Australia: Australian Government Publishing Service; 1991.
22. Appel LJ, Miller ER III, Seidler AJ, Whelton PK. Does supplementation of diet with “fish oil” reduce blood pressure? *Arch Intern Med*. 1993;153:1429–1438.
23. Morris MC, Sacks F, Rosner B. Does fish oil lower blood pressure? A meta-analysis of controlled trials. *Circulation*. 1993;88:523–533.
24. Shimokawa H, Vanhoutte PM. Dietary  $\omega$ 3 fatty acids and endothelium-dependent relaxations in porcine coronary arteries. *Am J Physiol*. 1989;256 (*Heart Circ Physiol*: 25):H968–H973.
25. Yin K, Chu ZM, Beilin LJ. Blood pressure and vascular reactivity changes in spontaneously hypertensive rats fed fish oil. *Br J Pharmacol*. 1991;102:991–997.
26. Chu ZM, Yin K, Beilin LJ. Fish oil feeding selectively attenuates contractile responses to noradrenaline and electrical stimulation in the perfused mesenteric resistance vessels of spontaneously hypertensive rats. *Clin Exp Pharmacol Physiol*. 1992;19:177–181.
27. McVeigh GE, Brennan GM, Cohn JN, Finkelstein SM, Hayes RJ, Johnston GD. Fish oil improves arterial compliance in non-insulin-dependent diabetes mellitus. *Arterioscler Thromb*. 1994;14:1425–1429.
28. Lorenz R, Spengler U, Fischer S, Duhm J, Weber PC. Platelet function, thromboxane formation and blood pressure control during supplementation of the western diet with cod liver oil. *Circulation*. 1983;67:504–511.
29. Yoshimura T, Matsui K, Ito M, Yunohara T, Kawasaki N, Nakamura T, Okamura H. Effects of highly purified eicosapentaenoic acid on plasma  $\beta$  thromboglobulin level and vascular reactivity to angiotensin II. *Artery*. 1987;14:295–303.
30. Chin JPF, Gust AP, Nestel PJ, Dart AM. Fish oils dose-dependently inhibit vasoconstriction of forearm resistance vessels in humans. *Hypertension*. 1993;21:22–28.
31. Chin JPF, Gust AP, Dart AM. Indomethacin inhibits the effects of dietary supplementation with fish oils on vasoconstriction of human forearm resistance vessels in vivo. *J Hypertens*. 1993;11:1229–1234.
32. Swann PG, Parent CA, Croset M, Fonlupt P, Lagarde M, Venton DL, Le Breton GC. Enrichment of platelet phospholipids with eicosapentaenoic acid and docosahexaenoic acid inhibits thromboxane  $A_2$ /prostaglandin  $H_2$  receptor binding and function. *J Biol Chem*. 1990;265:21692–21697.
33. Hashimoto M, Shinozuka K, Gamoh S, Tanabe Y, Hossain MS, Kwon YM, Hata N, Misawa Y, Kunitomo M, Masumura S. The hypotensive effect of docosahexaenoic acid is associated with the enhanced release of ATP from the caudal artery of aged rats. *J Nutr*. 1999;129:70–76.
34. Vandongen R, Mori TA, Burke V, Beilin LJ, Morris J, Ritchie J. Effects on blood pressure of  $\omega$ 3 fats in subjects at increased risk of cardiovascular disease. *Hypertension*. 1993;22:371–379.
35. Leaf A, Kang JX. Dietary n-3 fatty acids in the prevention of lethal cardiac arrhythmias. *Curr Opin Lipidol*. 1997;8:4–6.
36. Pepe S, McLennan PL. Dietary fish oil confers direct antiarrhythmic properties on the myocardium of rats. *J Nutr*. 1996;126:34–42.
37. Hallaq H, Sellmayer A, Smith TW, Leaf A. Protective effect of eicosapentaenoic acid on ouabain toxicity in neonatal rat cardiac myocytes. *Proc Natl Acad Sci U S A*. 1990;87:7834–7838.
38. Abeywardena MY, McLennan PL, Charnock JS. Differential effects of dietary fish oil on myocardial prostaglandin  $I_2$  and thromboxane  $A_2$  production. *Am J Physiol*. 1991;260(pt 2): H379–H385.
39. Pepe S, McLennan PL. A maintained afterload model of ischemia in erythrocyte-perfused isolated working hearts. *J Pharmacol Toxicol Methods*. 1993;29:203–210.
40. Kang JX, Leaf A. Protective effects of free polyunsaturated fatty acids on arrhythmias induced by lysophosphatidylcholine or palmitoylcarnitine in neonatal rat cardiac myocytes. *Eur J Pharmacol*. 1996;297:97–106.
41. Weylandt KH, Kang JX, Leaf A. Polyunsaturated fatty acids exert antiarrhythmic actions as free acids rather than in phospholipids. *Lipids*. 1996;31:977–982.



## Docosahexaenoic Acid but Not Eicosapentaenoic Acid Lowers Ambulatory Blood Pressure and Heart Rate in Humans

Trevor A. Mori, Danny Q. Bao, Valerie Burke, Ian B. Puddey and Lawrence J. Beilin

*Hypertension*. 1999;34:253-260

doi: 10.1161/01.HYP.34.2.253

*Hypertension* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231

Copyright © 1999 American Heart Association, Inc. All rights reserved.

Print ISSN: 0194-911X. Online ISSN: 1524-4563

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://hyper.ahajournals.org/content/34/2/253>

**Permissions:** Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Hypertension* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the [Permissions and Rights Question and Answer](#) document.

**Reprints:** Information about reprints can be found online at:  
<http://www.lww.com/reprints>

**Subscriptions:** Information about subscribing to *Hypertension* is online at:  
<http://hyper.ahajournals.org/subscriptions/>